



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ASCENDANT ANESTHESIA
25 HIGHLAND PARK VILLAGE SUITE 100-775
DALLAS TX 75205

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-11-1687-01

MFDR Date Received

JANUARY 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated January 25, 2011: "The carrier has denied payment stating the payment in is included in surgery procedure. This denial is incorrect. This bill is for the anesthesia services provided by the CRNA for this date of service. We have received payment for Code 64415 59 which was billed by this same provider for post operative pain management. That code was billed with modifier 59 which indicates that it is a **separately billed procedure** and is to be reimbursed separately from the anesthesia procedure."

Requestor's Position Summary dated March 21, 2011: "We have received a partial payment from the carrier for this outstanding code. The carrier has reduced their reimbursement by deducting \$133.14, stating they this amount was previously overpaid. This reduction is incorrect. The previous payment for the pain block was due to the provider, as well as this payment for the anesthesia procedure."

Amount in Dispute: \$352.92 minus payment of \$247.10 = \$105.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated March 1, 2011: "In the Request for Medical Fee Dispute Resolution, the Requestor seeks additional payment for the anesthesia services associated with the surgical procedure. The Respondent's bill reviewer evaluated the submission and concluded that the anesthesia service should have been included in the surgery procedure billed and should not have been billed separately."

Respondent's Position Summary dated March 10, 2011: "The Carrier had the bill re-reviewed following its earlier MDR Response out of an abundance of caution and the review came back differently than it did initially. Please see attached hereto as Exhibit 'A' the new EOB issued in this matter along with the check for the amount that was the difference between the initial and more recent reviews. As reflected in the attached review, the Carrier agrees that reimbursement was owed for the procedure at issue in this Request for MDR but a previous procedure on the bill, an interscalene block for post op pain management (CPT code 64415) in the pre-op area, was overpaid in the amount of \$133.14. Accordingly, the Carrier has reduced the gross amount owed to reflect what it contends to be the proper payment."

Response submitted by: Lewis & Backhaus, PC.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2010	CPT Code 01630-QX	\$352.92 -\$247.10 = \$105.82	\$105.82

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 TexReg 626, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 97-Payment is included in the allowance for another service/procedure.
- U837-Anesthesia is included in the surgery procedure.
- W1-Workers compensation state fee schedule adjustment.
- Z710-The charge for this procedure exceeds the fee schedule allowance.
- Z664-Reimbursement is calculated using base units plus time units.

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code 134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 Texas Administrative Code §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$53.68..."

The requestor billed the disputed anesthesiology service using the "QX" modifier that is described as "Qualified nonphysician anesthetist with medical direction by a physician."

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

The Division reviewed the submitted anesthesia report and finds the anesthesia was started at 1445 and ended at 1630, for a total of 105 minutes. Per Trailblazers Health Enterprises, LLC 2010 Anesthesia Manual "The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth." Therefore, the requestor has supported $105/15 = 7$.

Per 28 Texas Administrative Code §134.203(b)(1) the base unit for CPT code 01630 is 5.

The DWC Conversion Factor is \$54.54.

Per Trailblazers Health Enterprises, LLC 2010 Anesthesia Manual "Services furnished by qualified anesthetists are subject to the Part B deductible and coinsurance. If the Part B deductible has been satisfied, payment is based on 80 percent of the actual charge or 80 percent of the allowable amount utilizing the anesthesia calculation, whichever is less."

The MAR for CPT code 01630-QX is: (Base Unit of 5 + Time Unit of 7) X \$54.54 DWC conversion factor = \$654.48. This amount X 80% for CRNA = \$523.58 Previously paid by the respondent is \$247.10. The difference between the MAR and amount paid is \$276.48. The requestor is seeking dispute resolution for \$105.82: this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$105.82.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$105.82 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	6/20/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.